DOCUMENT RESUME

ED 234 285 CG 016 879

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TITLE Therapy without Therapists: Recent Research on Bibliotherapy and Other Minimal Contact Treatments.
PUB DATE Apr 82
NOTE 13p.; Paper presented at the Annual Convention of the Rocky Mountain Psychological Association (Albuquerque, NM, April 28-May 1, 1982).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Alcoholic Beverages; *Behavior Change; *Bibliotherapy; Case Studies; Counseling Techniques; *Drinking; Drug Rehabilitation; *Program Effectiveness; Psychotherapy; *Self Control; *Self Help Programs

ABSTRACT

Self-help programs can be used to replace, complement, or supplement formal treatment, but their effectiveness has been underestimated. To test the effectiveness of bibliotherapy in the treatment of problem drinkers, six studies were conducted over 7 years (1975-1982) comparing different treatment approaches. The combined data showed that for bibliotherapy clients who received nothing but a self-help manual, initial evaluation, and self-monitoring cards, the overall improvement rates were 78% at termination, 80% at 3-6 month follow-up, and 73% at 24 months. For all clients treated by all other methods combined the comparable rates were 82% at termination, 76% at 3-6 month follow-up, and 67% at 24 months. The success rate of bibliotherapy could not be attributed to seeking further treatment. Results suggest that bibliotherapy can provide critical conditions for change by providing information for the contemplation process, motivational techniques to help individuals reach determination, and specific strategies for active change. Supplmentary use of self-help is potentially useful in the maintenance stage of the change process as well. (JAC)

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THERAPY WITHOUT THERAPISTS:
RECENT RESEARCH ON BIBLIOTHERAPY AND OTHER MINIMAL CONTACT TREATMENTS

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CG016879

Paper presented at the Annual Convention of the Rocky Mountain Psychological Association, Albuquerque, NM, April 28-May 1, 1982.

THERAPY WITHOUT THERAPISTS
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William R. Miller, Ph.D.
University of New Mexico

(Paper presented as an invited address at the annual meeting of the Rocky Mountain Psychological Association, Albuquerque, April, 1982.)

I would like to begin by briefly presenting two cases of problem drinkers treated in our clinic at the University of New Mexico. Both came to our clinic because they were concerned about some aspects of their drinking, and wanted to learn how to better control their use of alcohol.

The first case we will call Leah. She was a 60 year old grandmother, married to a 62 year old retired railroad worker now employed as a night watchman. She reported no problem with drinking prior to her 50's, when her drinking began to increase slowly to her present level of about 32 drinks per week. (One "drink" for the purposes of this paper is equal to 10 ounces of beer, 4 ounces of table wine, or about one ounce of distilled spirits.) She drank mostly at night while her husband was working, consuming between 4 and 8 ounces of bourbon on nights when she drank. She had had some memory blackouts, and had experienced some withdrawal tremor on mornings after heavy drinking. We interviewed three collaterals including her husband, and all three were surprised to learn that she was in treatment for her drinking. All believed her to be a very light drinker, estimating her consumption at about two drinks per week. Clearly Leah was a hidden drinker.

Over the course of treatment she showed a rapid decrease in her drinking, then a partial rebound, and finally a gradual decrease over 18 weeks until, at termination, her consumption was reported at 7 drinks per week. Her collaterals again confirmed this low level of consumption, although their accuracy is to be questioned given their underestimation at intake. At 6 month follow-up, Leah reported having about 3 drinks per week. Now, however, her collaterals estimated her drinking at 18 drinks per week. This points out one difficulty of alcohol research, because none of these collaterals actually observed her drinking. Rather they seemed to have been sensitized by her participation in alcohol treatment, and guessed that she was drinking secretly. Thus if one looks only at collateral reports here, it looks like her drinking has become much worse!

By 12 month follow-up, Leah's self-reported drinking had stabilized around 6 drinks per week (1½ oz. of bourbon on four days of the week). Collaterals now confirmed this moderate level. Her blood alcohol concentration declined from an estimated peak of 156 mg% at intake (from regular weekly drinking) to 30-40 mg% at 12 months. She reported confidence that drinking would no longer cause her problems.

A second case we will call Richard, a 43 year old manager of a retail store. Richard was married with two children, but separated when he first contacted our clinic. The separation was due to his drinking, and this seemed to provide the motivation for his seeking treatment, because he wanted to reconcile the marriage.

Richard had many symptoms of problem drinking: blackouts, hangovers, nausea and vomiting. His liver function values indicated marginal elevations, suggesting the beginning of some damage. Yet his history included no symptoms of alcohol withdrawal. About once a month he stopped drinking for 2-3 days with no detrimental physical symptoms. By DSM-III standards his diagnosis would be Alcohol Abuse, but probably not Alcohol Dependence.

Richard's father was an alcoholic, his mother a teetotaler. His drinking had accelerated rapidly 6 years previously when he received a promotion at work. He was consuming the equivalent of a pint of scotch daily, some after work and more at home, for a total of about 98 drinks per week. At his wife's insistence he had attended about 20 A.A. meetings, but he had stopped going because "I just didn't think I was that bad off."

By the end of the 18 week treatment period his drinking had declined to 28 drinks per week, still high but substantially less than at intake. He had been reunited with his wife, who confirmed that his drinking seemed to be under control. She was pleased with the outcome, but he reported still feeling tense, bored, and depressed. "I feel like I might slip at any time," he said.

At 6 month follow-up he had reduced his drinking still further, to 20 drinks per week, and this was fully confirmed by his collaterals. His blood alcohol level was hovering around 50 mg%, less than a quarter of what it had been. At 9 months, however, he had a relapse, returning to his pretreatment level of drinking for one week, after which he stopped drinking completely. At 12 month follow-up he was still abstaining except for one private "slip" unknown to any of his collaterals, on which he drank 8 oz. of scotch on each of 2 days to test his control. He felt encouraged by his success, stopped drinking again, and had not resumed. His abstinence continued at 24 months, by which time he had accumulated 14 months of sobriety. His liver function values were now well within normal range.

Thus here we have two cases, both treated with a goal of controlled drinking, one of whom attained, the other of whom chose and succeeded at abstinence. What they have in common is that both were involved in a research project in which the only "treatment" they received was a self-help manual.

Are these accidents or exceptions? I will maintain that they are not, and that we have grossly underestimated the potential of self-help treatment methods. It is clear that many people change problem behaviors without ever receiving the help of a therapist. They have the audacity to get better without professional help! Probably the majority of change occurs outside of the context of any professional helping relationship, and we are only beginning to understand the process of change in this larger context. What are the critical conditions for change? I cannot address this large question today, but I do want to look closely at the process of self-help prescribed as treatment.

There are several possible ways to use self-help resources such as manuals. These four methods have been described by Christensen, Miller, and Munoz in an earlier paper. They can be used as <u>replacement</u>, instead of formal treatment, or as a <u>complement</u> to treatment, as when the therapist focuses on one problem area while the client uses self-help procedures to work on another. They may also be <u>concomitant</u> resources to focus on the same problem being treated by the therapist - a dual-pronged approach. Finally they may be used to <u>supplement</u> treatment after the formal therapy is finished, to improve maintenance of gains or otherwise reinforce the accomplished change.

My own interest in self-help as therapy arose quite accidentally, as a result of a series of unexpected and serendipitous findings over my past 7 years of research. I will attempt to summarize these 7 years of research and thinking in the next 45 minutes - about 6 minutes a year. Obviously I am going to skip over many of the details of methodology and focus on major findings. If you are interested in more of the details of these studies, they have been published and I will be glad to provide you with references.

My research began at the University of Oregon, where I undertook to compare three different treatment approaches for training controlled drinking to problem drinkers. In this study (Miller, 1978), all three methods proved fairly successful at one year follow-up, but the important finding for today's purposes was one that occurred after treatment, really as a byproduct or afterthought. I decided that since we had focused solely on drinking in this treatment program, it might be beneficial for our clients to have a self-help reference to use after their formal contact with the therapist had ended (a "supplement" use of a manual, as outlined earlier). In the manual we included both self-control instructions for drinking and more broad-spectrum instructions for self-help methods such as relaxation training, assertion, etc. Then I thought the better of this, and decided that I should evaluate whether giving this manual would influence our follow-up. For this reason I gave the manual only to half of our clients at termination, with the other half (randomly selected) receiving no manual. We did not expect the manual to have any effect on follow-up, but were surprised to find at 3 months that indeed it had. Clients who had received the manual showed significantly better continued improvement than did those not receiving it, with the latter group remaining where they had been at termination. One complication of this was that some of the clients given the manual had not read it. This peculiar group showed most "improvement" of all! This may be understood, however, by the fact that these same clients were substantially more improved at termination when they received the manual, and they reported that they had not read it because they thought they did not need it. The "readers" on the other hand looked like those who did not receive the manual at the outset, but showed increasing gains over the nonreceivers as follow-up continued. Whether or not we combined the nonreaders and readers, those receiving the manual did significantly better.

This raised an interesting question which was the substance of our next study: how much could a self-help manual do on its own, and how much better would clients do when working with a therapist? To our surprise we found that both groups showed excellent improvement comparable to that in our first study, and that there were no significant differences between groups. At 3 month follow-up the improvement rate was 80% in the therapist-treated group, 88% in the bibliotherapy group (Miller, Gribskov, & Mortell, 1981).

At this point I moved to the San Francisco Bay area where I conducted a third study, this time an uncontrolled demonstration project looking at the possibility of offering this type of behavioral self-control training in a group "classroom" setting. We recruited problem drinkers interested in learning moderation, offering self-control classes through a local community center. The program was announced in the major newspapers of San Jose and San Francisco, reaching about 2 million people. We wound up with a total of 28 clients, which confirmed our earlier experience - that announcing a program like this in the news media does not produce a flood of applicants, nor did we find large (or even small) numbers of chronic alcoholics applying. Rather our applicants were mostly nonaddicted problem drinkers.

In this study we used the self-help manual as a textbook for the course. At this point we had a prepublication manuscript of How to Control Your Drinking (Miller & Munoz, 1976), which was released later that year by Prentice-Hall. This was an expanded and rewritten version of the manual we had evaluated in the two earlier studies. This manual is now out of print, but a revised edition has been released by University of New Mexico Press. It describes in detail the treatment procedures used in these studies. Our outcome (Miller, Pechacek & Hamburg, 1981) showed a 71% success rate at 3 months. We were less satisfied with this outcome, however, because most of the clients fell into our intermediate "improved" category and few met all of our criteria for controlled drinking. In order to be considered a controlled drinker, a client must be drinking not more than 20 drinks per week (or about 3 drinks a day - with drink defined as mentioned earlier), and not exceeding 80 mg% blood alcohol level in an average week, and self-report must not be contradicted by collateral reports.

When I moved to Albuquerque in 1976 I decided to try to replicate what we had done before, partly because I still didn't believe the bibliotherapy finding. Bibliotherapy had been, after all, my "no treatment" control! Thus in our fourth study we randomly assigned clients to one of four conditons: bibliotherapy only, 10 weeks of therapist-guided self-control training, 10 weeks of individual self-control training plus relaxation training, or 10 weeks of group therapy focusing on the same material. (Actually the last of these groups was not assigned at random because of the delay it would have required for other clients while the group was being constituted. Thus the first three were randomly assigned, and then the final ten clients were treated together as a group.)

To give you a sense of the kind of clients were were treating, their average age was 45, and mean family income (with wide variation) was about $24,000. Likewise mean education was a little under 16 years, varying from some high school to several doctoral level professionals. On the average they had been having alcohol-related problems for 10 years, and were consuming 54 drinks per week. On the Michigan Alcoholism Screening Test they averaged between 18 and 19, well within the range considered "alcoholic" by the scale's author. 61% were male, 76% were married, and 61% had never been treated for problem drinking before. In terms of dependence symptoms, 85% reported hangovers, 76% had had blackouts, 29% reported craving for alcohol, 22% had experienced mild withdrawal in the form of tremors, 20% reported loss of control over drinking on most occasions, and 15% drank in the morning. None had experienced withdrawal symptoms more serious than tremor because such clients were excluded from the study as inappropriate for controlled drinking. In this way our study differed from that of the Sobells (1973) in that they worked only with gamma alcoholics, whereas we excluded gamma alcoholics from our sample.

As in our earlier studies all groups showed significant decreases in weekly consumption and blood alcohol levels, and these were well confirmed by collateral sources. Over our seven years of research, in fact, we have found quite good correspondence between self-report of clients and collateral reports of their significant others. In many cases, clients themselves report heavier drinking than is known by their collaterals.

Once again, no differences among groups emerged. In the two individually treated groups, the improvement rate at 2 years was 74%, compared with 75% in the bibliotherapy group. The only group with better outcome was the group therapy condition, which was maintaining at 90% successful at 2 years. The difference was not statistically significant, however. (Miller & Taylor, 1980)

In a fifth study (Miller, Taylor & West, 1980) we wanted to determine whether a "broad spectrum" approach would improve outcome, so we compared the usual bibliotherapy and individual-therapist conditions with two other groups receiving more extensive treatment. The broad spectrum groups received, in addition to self-control training for moderation, 12 weeks of training in other life skills such as relaxation training, assertion and communication skills. In the bibliotherapy condition clients received both a copy of How to Control Your Drinking and their choice of up to three other free books dealing with other life problem areas. As in all of our previous research, no fees were charged for treatment.

Our findings were monotonously consistent. All groups showed marked drops in alcohol consumption and blood alcohol concentration. The bibliotherapy group in this study showed less improvement on one dimension: hours intoxicated per week. Otherwise there were no significant differences in efficacy. The two-year success rates were 70% in bibliotherapy, 55%, 60% and 40% in the other groups, respectively. We wonder if the more modest success of bibliotherapy in this study may have been due to the fact that we gave four books instead of one, thereby perhaps decreasing the impact of the primary manual. At any rate, bibliotherapy is still comparing favorably with other approaches. I might add that the improvement seen on drinking measures in these studies is also consistently echoed on other dimensions including mood, liver function, personality measures, etc.

One very obvious weakness of all of these studies is the absence of an untreated control (which is what the bibliotherapy group was originally intended to be). We therefore decided that in spite of the ethical problems inherent in no-treatment controls, it was time to do a study of this sort. It might be, for example, that the clients who come to us are in a real sense already changed, and that they would improve no matter what they did in treatment. Likewise our clients consistently point to the value of self-monitoring in increasing their awareness and control of drinking, and it might be that monitoring alone (a very reactive procedure) accounts for the changes since this has been part of our bibliotherapy condition since the very first study.

We designed the sixth study to answer these questions. Clients were assigned at random to four groups: bibliotherapy, individual therapist, no treatment (waiting list), and self-monitoring waiting list. The latter two groups were untreated during the first phase of the program (10 weeks). One group simply waited for treatment, whereas the other kept self-monitoring records. Neither received the manual. The bibliotherapy group also was not given formal treatment, but was given the manual and did keep self-monitoring records. My expectation was that the self-monitoring group at least would show improvement, perhaps comparable to that in the bibliotherapy group, and that the untreated control might also show improvement.

Again we were surprised. The bibliotherapy group and individual-therapist group both showed good gains comparable to those seen in earlier studies, each showing 75% improved rates at the end of treatment phase 1. The untreated control was unchanged, however (a modest improvement rate of 33%, with no abstainers or controlled drinkers), and the self-monitoring control (13% improvement) actually looked worse on most drinking measures. The latter two groups were then treated in group format, and their improved rates jumped to 56% and 75% at follow-up of 3 months. At 12 month follow-up, these two groups maintained at 56% and 50% improved, respectively, whereas therapist-treated clients maintained at 75% and bibliotherapy at 88%. ("Improved" here includes clients confirmed as abstainers or controlled drinkers, as well as those showing significant reductions in drinking even though they fall short of controlled drinking.)

If we combine data from all of these studies, the following picture emerges. For bibliotherapy treated clients - those receiving nothing but a self-help manual, initial evaluation, and self-monitoring cards, the overall improvement rates are 78% at termination, 80% at 3-6 months, 73% at 12 months, and 73% at 24 months. Among therapist-treated cases, the following rates obtain: 80% at termination, 81% at 3-6 months, 69% at 12 months, and 73% at 24 months (when clients receiving only behavioral self-control training are considered). If all clients treated by all methods are combined, the comparable rates are 82%, 76%, 68%, and 67%. The attached figure shows the composition of these improvement rates. There is a clear tendency over time for "improved" cases - those sitting on the fence, so to speak - to either relapse or remit into abstinence or controlled drinking. Interestingly the percentage of controlled drinkers remains fairly constant over time, except in the bibliotherapy condition where there is an increase at 24 months.

An important question, given this latter finding, is whether these clients obtained other treatment accounting for their gains. Were this the case, the bibliotherapy outcome statistics would be less interesting. Of 22 bibliotherapy clients followed for 2 years, 6 reported having sought further treatment. (Attendance at A.A. was considered to be further treatment.) Of these, two were abstinent, two were controlled drinkers, one was improved, and one was unimproved. Of cases not receiving further treatment, one was abstinent, nine were controlled drinkers, one was improved, and none were unimproved. Five cases could not be interviewed, and in our overall analyses we always consider unlocated cases to be treatment failures. Whether or not these individuals had received further treatment is unknown. Thus it appears that the success rate of the bibliotherapy groups cannot be attributed to seeking further treatment.

How unique is this finding to the alcohol area? It appears that it may not be unique at all. Other researchers have found encouraging success rates for clients using self-help procedures in a range of other problem areas including anxiety disorders, sexual dysfunctions, and children's behavior problems. In our own laboratory we have completed two studies including bibliotherapy control groups, focusing on the treatment of depression. In the first of these (Miller, Katz & Koons, in preparation), we found that depressed college students using a self-help manual showed significant improvement comparable to that shown by groups receiving the same treatment strategies (cognitive-behavioral) under therapist direction. Michael Schmidt, one of my doctoral students, followed this up with a dissertation comparing bibliotherapy, individual, small- and large-group therapy for depression with an untreated waiting list control. In his study, the waiting list group showed no improvement whatsoever on mood measures, whereas all other groups showed substantial improvement. The bibliotherapy group was as good as the best in this study. When the waiting list control group was treated during phase 2, they improved to a level comparable to that of the other groups. It appears that for depression, too, self-help measures may be effective - at least for the types of moderately severe depression often seen in outpatient settings.

What are we to make of this as therapists? At first exposure to these data, professional therapists often become defensive and look for ways to discredit the findings. I am convinced, however, that there is a consistent and valid trend emerging in the field here - that at least under certain conditions, with certain problems, certain types of clients can be very effectively helped by self-help approaches.

I would immediately note some caveats. First of all, we must define the "self-help" method very carefully. I am not giving a blanket endorsement to all self-help books. Rather we must evaluate these one by one, just as we must evaluate the effectiveness of therapist-administered treatment procedures. Not all self-help approaches will be helpful. Some may be quite harmful, as Rosen and others have noted. I certainly do not wish, in this age of social service witch hunters, to suggest that all treatment agencies can be replaced with bookstores.

At the same time I do believe that treatment agencies can fruitfully begin to incorporate minimal-intervention approaches that are not second-class service. Some of our research suggests that for certain types of clients, therapist administered approaches may actually be less effective than self-help. If we learn how to apply these methods effectively, we need not apologize for them. If some clients can be effectively helped by minimal interventions, then therapists can devote their precious time to those clients who genuinely need this more extensive type of intervention.

Another exciting direction about this research is that it begins to point us toward a better understanding of the process of change. Apparently bibliotherapy, at least sometimes, can provide the critical conditions for change. One of the most helpful models of change that I have found has been proposed by Jim Prochaska and his colleagues in Houston. It describes four developmental stages of change. During Stage 1, Contemplation, the individual begins to consider the need for change - to think about the possibility of change. Here the needed interventions have to do with information giving and awareness raising. Next, the stage of Determination is reached, in which contemplation reaches a kind of "critical mass" and the client decides that a change must occur. My own experience is that this is a kind of window that opens for a limited time. If during that critical period the individual advances to the third stage, then change progresses. If not, "motivation" is at least temporarily lost. The third phase is the one where therapists are most commonly used. This is the phase of Active Change. Here the individual needs specific alternatives to prior behavior patterns. Finally comes the stage of Maintenance in which the task is to retain the gains made during active change.

Bibliotherapy can, I believe, play a role in each of these phases. Information can be provided for the contemplation process, and motivational techniques may be included to help the individual reach determination. Certainly the specific self-change strategies described in many self-help resources are the type needed for active change. Our "supplementary" use of self-help is potentially useful in the maintenance stage as well.

In my own teaching I maintain that there are three critical conditions of change: awareness, acceptance, and alternatives. Awareness corresponds to the first two stages of the Prochaska model, and alternatives to the latter two stages. What bibliotherapy may not be able to provide is the other of these three conditions of change: acceptance. Here I refer to the extensive research of Carl Rogers and his students, suggesting that certain therapist qualities (empathy, warmth, andgenuineness) facilitate change. My own experience confirms this, and in one

study we found therapist empathy to be a powerful predictor of treatment outcome, even though the treatment procedures employed were behavioral in focus (Miller, Taylor & West, 1980). In fact, high empathy therapists in this study proved more effective than bibliotherapy alone, whereas clients using only a self-help manual fared better than did those working with a low empathy therapist. The bottom line of this is that although a manual may not be able to provide empathy and acceptance in the traditional therapeutic sense, this may not be an essential condition for change in all clients (or they may receive their acceptance elsewhere, as from social support systems.) In fact, a "neutral" manual may be better than a therapist who provides low levels of acceptance.

Other potential advantages of self-help approaches occur to me. Some individuals simply may respond better to self-control than to therapist direction. I was surprised to find, in our research in which people were randomly assigned, that those placed in bibliotherapy were often relieved, enthusiastic, and only seldom disappointed. We endeavored to present bibliotherapy as a positive and potentially successful approach (and now can do so with even more integrity), so that expectancy may have played an important role. Nonetheless, clients often responded very well to a self-help orientation. This is certainly consistent with recent emphases on internal attribution for change and on self-efficacy as a therapeutic cognition.

Individuals may also be willing to pursue self-help approaches sooner than they would seek formal treatment. The abovementioned research does not address this issue because all clients had already asked for help from a treatment program. A self-help approach, however, circumvents some of the feared stigma and labeling, protecting the person's anonymity.

All of these advantages would be for naught, however, if self-help approaches were ineffective. What is encouraging to me is the amount of promising results emerging from bibliotherapy research. To be sure there are problem areas where self-help may be less effective. Studies on bibliotherapy for smoking cessation and weight loss have been less encouraging. What remains is for us to advance our understanding of how people change, so that we may help them do so with or without the traditional intervention modalities of our mental health systems.

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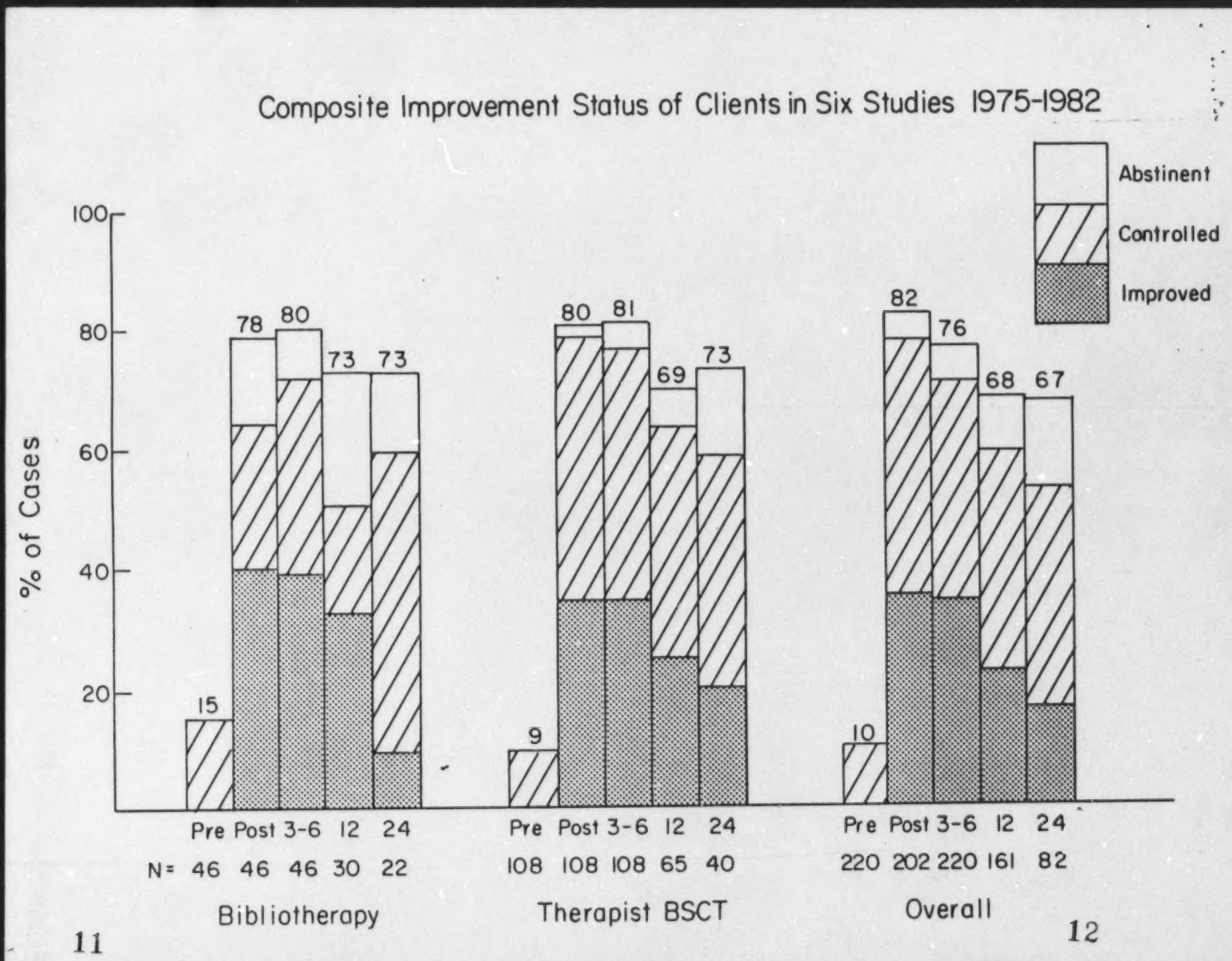
Composite Improvement Status of Clients in Six Studies 1975-1982
Abstinent
Controlled
Improved
% of Cases
100
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Pre Post 3-6 12 24
N= 46 46 46 30 22
Bibliotherapy
Pre Post 3-6 12 24
108 108 108 65 40
Therapist BSCT
Pre Post 3-6 12 24
220 202 220 161 82
Overall

11

12

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